STUDY
ON
HIGH COST MEDICAID INFANTS

PRESENTED
TO

LEE J. TICKELL, ADMINISTRATOR
ECONOMIC ASSISTANCE DIVISION

BILL HARRINGTON, CHIEF
FIELD AND PROGRAM MANAGEMENT BUREAU

JOHN CHAPPUIS, CHIEF
MEDICAID SERVICES BUREAU

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

BY
PRENATAL CARE COMMITTEE

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SUMMARY

I. SUMMARY:

The Omnibus Reconciliation Acts of 1985, 1986 and 1987 allowed states a number of options in extending Medicaid benefits to pregnant women and to children. In an effort to determine which, if any, of the options would be appropriate for Montana to select, the Economic Assistance Division of the Department of Social and Rehabilitation Services established a study committee in May of 1988.

The committee focused on high cost infants born in 1986 and their mothers. ("High cost" was defined as over $10,000 in Medicaid expenditures during the first year of life.) Through a computer search, 83 infants were categorized as high cost. Only eighty-one (81) mothers were included in the study since five of the high-cost infants were twins.

These 83 babies represented only 2.7% of the 3031 infants covered by Medicaid during 1986. However, the Medicaid costs associated with this group of 83 infants totaled $2,696,461 or 50.6% of the entire expenditures for Medicaid infants during that calendar year.

The committee attempted to:

1. Determine whether the high costs of these infants were associated with premature birth and low birth weight; and

2. Identify the barriers that the mothers of these infants may have faced in accessing prenatal care.

Over half (55.4%) the infants in the study were low birth weight. Compared to all the women who gave birth in Montana during 1986, the study group of mothers was characterized by their youth, their high incidence of out-of-wedlock births, and their lack of a basic (high school) education. Whereas the vast majority of mothers in the study group were Caucasian (80.0%), it is important to note that Indian women are over-represented in the sample.

These findings are consistent with national studies which have identified certain factors which, if present, increase a woman's risk of delivering a low birth weight infant. The demographic risk factors include:

1. Age

2. Race

3. Low Socioeconomic Status

4. Unmarried

5. Low Level of Education

Although the majority of mothers in the study group fit the demographic high risk profile for delivering a low birth weight infant and many of the mothers had severe medical problems, most (66.2%) of the mothers in the study group received inadequate prenatal care.

The vast majority of these women were eligible for Medicaid with no incurment (79.7%). However, nearly two-thirds of these women (62.9%) did not apply for Medicaid benefits until shortly before or immediately following the birth of the child.

INTRODUCTION

II. INTRODUCTION:

During the past two years, many states and federal agencies have focused on a critical problem facing our nation -- namely, the high rates of infant mortality among low-income populations. During this same time period, Montana has been experiencing a crisis in obstetrical/gynecological health care delivery. This crisis has been due, in large measure, to the rapidly escalating costs of liability insurance. In 1986, 213 physicians in Montana offered these services. In 1987, the number dropped to 193 physicians and it is believed that 1988 saw a further decline in services to include only 152 physicians statewide. This decline represents a 29% reduction of obstetrical/gynecological (OB/GYN) services.

In addition, not all physicians who offer OB/GYN services extend these services to Medicaid recipients. This is largely due to the significant difference (60%) between customary charges for OB/GYN services in Montana and Medicaid payments.

In May of 1988, an Economics Assistance Divisional committee was established to review Medicaid options for pregnant women, to determine the feasibility of adopting such options in Montana, and to make recommendations to the Department administrators prior to the 1989 legislative session.

Members of the committee are:

Dee Capp, Administrative Officer III, Primary Care Section, Medicaid Services Bureau

Judy Garrity, Management Analyst III, Policy and Training Section, Field and Program Management Bureau

Pat Huber, Administrative Officer III, Medicaid Therapies and Pharmacies Section, Medicaid Services Bureau

Penny Robbe, Supervisor, Policy and Training Section, Field and Program Management Bureau

Medicaid options include the following:

A. PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN:

The Omnibus Reconciliation Act of 1986 (OBRA 86) allows states to provide an optional period of presumptive eligibility to pregnant women in order for them to receive prompt prenatal services.

If a qualified Medicaid provider determines that the pregnant woman's family income does not exceed a specific standard, that provider certifies that the pregnant woman is presumptively eligible. The pregnant woman can then receive prenatal services for a period of 14 to 45 days. If the woman does not file an application for Medicaid with the county office within 14 days, the

presumed eligibility continues until the county makes a final determination or 45 days, whichever is earlier.

States have the option of requiring the qualified Medicaid provider to determine resource eligibility or any other eligibility factors if they so desire.

Qualified Medicaid providers may be chosen by the states as long as they meet various federal criteria. Some examples could be county health departments or WIC programs.

B. COVERAGE OF POOR PREGNANT WOMEN AND INFANTS TO AGE ONE YEAR AT 185% OF POVERTY):

With the enactment of OBRA 1987, states are allowed to provide coverage for pregnant women and infants to age one year if the family's income does not exceed 185% of the official poverty level for that family size. A resource test is optional for this group. (185% of poverty for a family of three is currently $17,926.50.)

In this program, the states cannot choose to separate coverage for pregnant women and infants. If coverage is extended for one group, it must be extended for the other group as well.

C. EXTENDED COVERAGE TO POVERTY PREGNANT WOMEN AND INFANTS UP TO AGE ONE:

The Catastrophic Coverage Act of 1988 mandates states to extend Medicaid benefits to pregnant women and infants up to age one with incomes at or below 100% of the federal poverty level. Coverage will be phased in beginning July 1, 1989, with those women and infants whose income is at or below 75% of the poverty level. Effective July 1, 1990, women and infants with income within 100% of the poverty level will be potentially eligible for Medicaid benefits. A resource test is optional.

D. EXPANDING THE PROVIDER BASE FOR PRIMARY HEALTH CARE SERVICES:

The Medicaid Bureau is reviewing options which may expand the provider base of primary health care services, such as prenatal services. Some possibilities which are being reviewed are: public health departments with physician directors providing physician services and billing Medicaid for such services; working with the nurse specialists to become Medicaid providers and bill for services; reviewing the feasibility of allowing a health care facility, such as a hospital, to provide outpatient physician services such as prenatal clinics; and evaluating the potential for family planning clinics to provide additional primary health care services.

The review by staff will include the providers' interest in participating with Medicaid to provide the services, reimbursement issues, and the scope of services allowed by federal regulations and state law for the various provider types.

Crucial issues in providing prenatal and delivery services to the Medicaid clientele are the ability to attract qualified health care providers and the level of Medicaid reimbursement for the services.

E. CASE MANAGEMENT:

Under the Consolidated Omnibus Reconciliation Act of 1985 (COBRA), state Medicaid programs were given flexibility to implement targeted case management systems and to develop enhanced benefit packages for pregnant women.

The economic status of low-income women is one factor which increases their risk of giving birth to a low birth weight or otherwise unhealthy infant. A woman's health status, environmental conditions and psychosocial elements within the family structure must also be evaluated when determining her risk factors.

A case management option could be developed under Medicaid services. The case management system would assist the individual in obtaining the necessary health services as well as assessing her social, economic and environmental influences. While the physician would be primarily responsible for determining the medical needs and treatment plan, the case management broker would implement the plan and assist the client in obtaining the necessary services.

A case management system further insures that "presumptive" eligibles (if that option is selected) follow through with a formal Medicaid application.

As case management is considered an optional service, the Legislature must review and approve Medicaid's capability to implement such a service. Case management services applied to one group may also apply to the health care management of other catastrophic illnesses such as AIDS, long term chronically ill, brain stem injured individuals, or respirator-dependent individuals.

F. CONTINUOUS ELIGIBILITY:

OBRA '86 also allows states to implement programs that guarantee an eligible woman uninterrupted coverage throughout her pregnancy, regardless of fluctuations in her family income or resources. Periodic redetermination of eligibility could then be eliminated for this group.

METHODS, ORGANIZATION AND LIMITS

III. METHODS, ORGANIZATION, AND LIMITS:

A. METHODS AND ORGANIZATION:

In order to determine which of the OBRA options (if any) would be appropriate for Montana to consider, more information was required. By assessing how pregnant women and infants are now faring in Montana, we could then decide what needs to be done to improve their access to and use of medical services.

We decided to look at Medicaid babies (born within a particular calendar year) and their mothers. 1986 was chosen as the study year, since Medicaid claims would be completed for that period of time. The Montana Income Maintenance System (MIMS) indicated that 3031 infants were covered by Medicaid within the calendar year of 1986. The Medicaid costs associated with this group of infants totaled $5,326,002.

Since the entire group of 3,031 infants would have been far too time consuming to study, it was decided to study only those infants whose Medicaid costs exceeded $10,000 during the first year of life. MIMS indicated that 83 infants fell into this category. The Medicaid costs associated with this group of 83 infants totaled $2,696,461 or 50.6% of the entire expenditures for Medicaid infants during that calendar year.

An in-depth study was conducted on the 83 infants to determine whether their high costs were associated with premature birth and low birth weight. The study also attempted to identify the barriers that the mothers of these infants may have faced in accessing prenatal care.

The infants were identified by MIMS with social security number, date of birth, case number, and the amount of Medicaid dollars spent on their care during the first year of life. Mothers of the infants were then identified through the case number or, in some cases, by contacting the county offices.

Medicaid claim histories for both the infants and their mothers (if mothers were covered by Medicaid) were pulled using the Surveillance and Utilization Review System (S/URS). These claim histories provided information regarding the birth weight of the child, any congenital anomalies, type of medical procedures used, etc. The claim histories also indicated subsequent hospitalizations during the first year of life. Mothers' claim histories indicated any hospitalizations which may have occurred prior to the birth of the child or other medical/psychological problems which were being treated.

County welfare offices of the study group were contacted and asked to fill out forms and return them to the state office. The form identified the mother by name and social security number and indicated a time period which spanned nine months prior to the birth

of the child as well as the month of the child's birth. Counties were asked to look at the case records for these women and indicate:

1. The date(s) they applied for Medicaid coverage during this time span;
2. The date(s) of approval or denial;
3. The reason for any denials;
4. The date(s) of eligibility within the allotted time period; and
5. The amount of incurment, if any.

Demographics of the mothers of these high cost infants were manually manipulated with information gathered from MIMS or through county contacts. The women were grouped by age, race, and county of residence.

A review of the birth certificates of these high cost infants was made by the Bureau of Vital Statistics of the Montana Department of Health and Environmental Science. Birth certificates for only 65 of the babies could be found. (Some of these high cost infants were born in medical centers out of state.) The Bureau of Vital Statistics then gathered information on these 65 infants and compared the information to the total number of infants born in Montana during 1986. Computer comparisons were run on:

1. Age of mother at birth of the child;
2. Race of mother;
3. Marital status of mother;
4. Educational level of mother;
5. The number of prenatal visits of mother; and
6. The month prenatal care began.

Some physicians or hospitals were contacted to determine the amount of prenatal care these women received during their pregnancies. Initial contacts were made for those infants whose Medicaid costs exceeded $40,000 during the first year of life and whose mothers were covered by Medicaid at the time of birth.

Questions to which the providers responded are as follows:

1. When did the client first come to your office for prenatal care:
2. What was the expected date of delivery?
3. Was this client referred to you by another physician?
   If so, what month of the pregnancy was the referral made?
   What was the reason for the referral?
4. Was this pregnancy classified as high risk?
   If so, for what reason?
5. Number of prenatal visits provided by your office?
6. What was the birth weight of the baby?

B. LIMITATIONS OF THE STUDY:

The study group (65 infants and their mothers) was compared to the total number of babies born within Montana in 1986 and their mothers. It was not possible to compare the study group to all babies born in 1986 who were covered by Medicaid (3031 infants). Such a comparison would have involved identifying all 3031 infants and their mothers by name which would have taken an enormous amount of time and effort by a limited number of staff persons working on the study. It would have also involved a great deal of time spent by county staff.

It was also not possible to compare the study group to the overall welfare population in Montana in 1986 as the particular data is not available.

The data obtained from the study group was then compared to data on the total number of infants (and their mothers) born within the state in 1986. (Total state births for 1986 were 12,765.)

FINDINGS

IV. FINDINGS:

A. DEMOGRAPHICS:

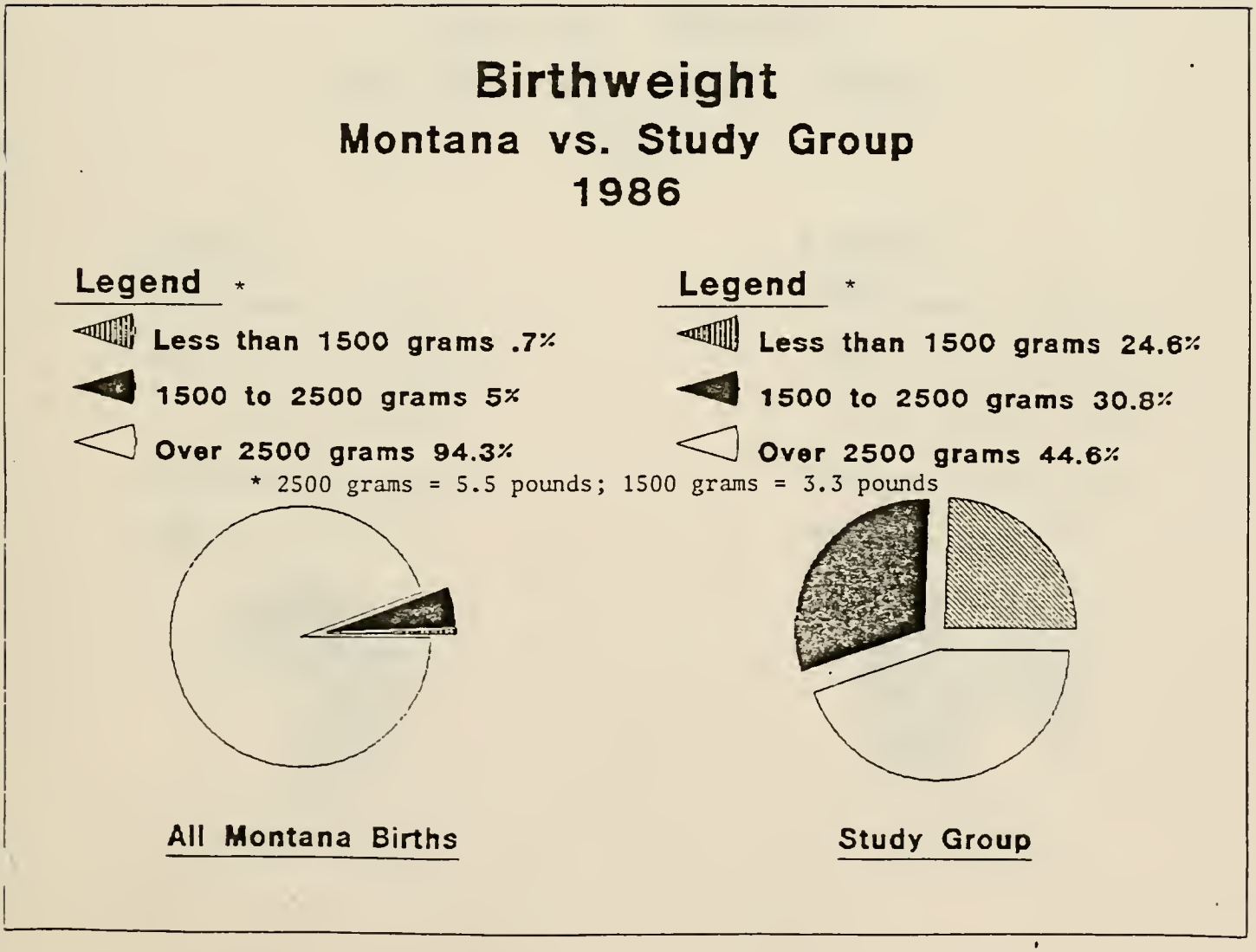
MONTANA GROUP

STUDY GROUP

BIRTH WEIGHT

During 1986, 5% of all babies born in Montana weighed between 1501 grams and 2500 grams. An additional .7% were very low birth weight or under 1500 grams. The total of low birth weight babies was 5.7%.

Within the study group, 30.8% of the babies weighed between 1501 grams and 2500 grams. An additional 24.6% were under 1500 grams. The total of low birth weight babies in the study group was 55.4%.



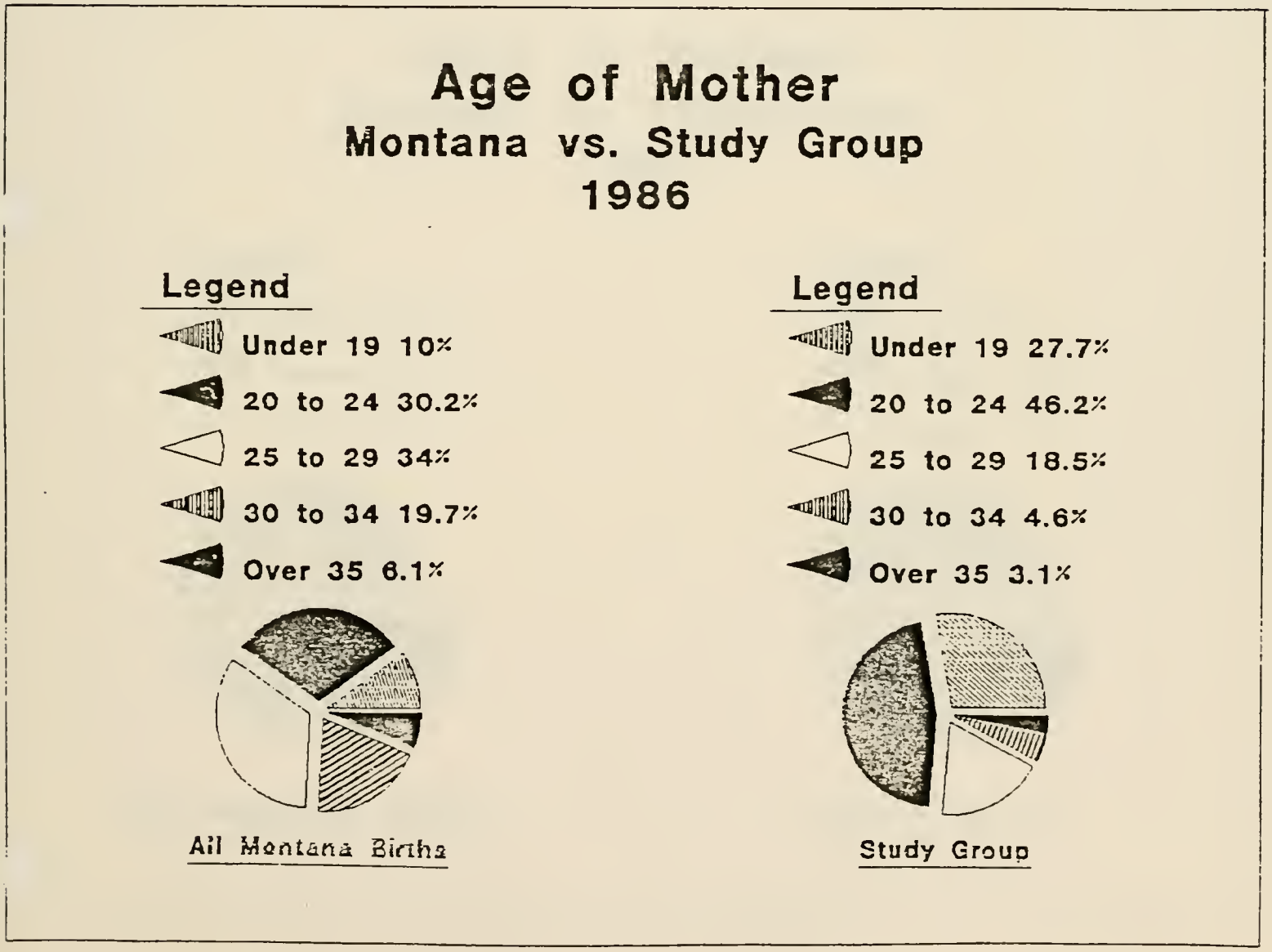
MONTANA GROUP

STUDY GROUP

AGE OF MOTHER

Of the 12,765 babies born in 1986, only 6 were born to women under the age of 15. (This did not calculate into a recordable percentage rate.) Ten percent (10%) of the state births were to women between the ages of 15 and 19. Another 30.2% of the births were to women between the ages of 20 and 24. Therefore, 40.2% of the women who gave birth in Montana in 1986 were under the age of 25.

Of the women in the study group, one mother or 1.5% was under the age of 15; 26.2% were between the ages of 15 and 19; and 46.2% were between the ages of 20 and 24. Total percentage of mothers in the study group under the age of 25 was 73.9% -- nearly twice the state average. Furthermore, the study group had a much higher incidence of teen births -- almost three times the state average.



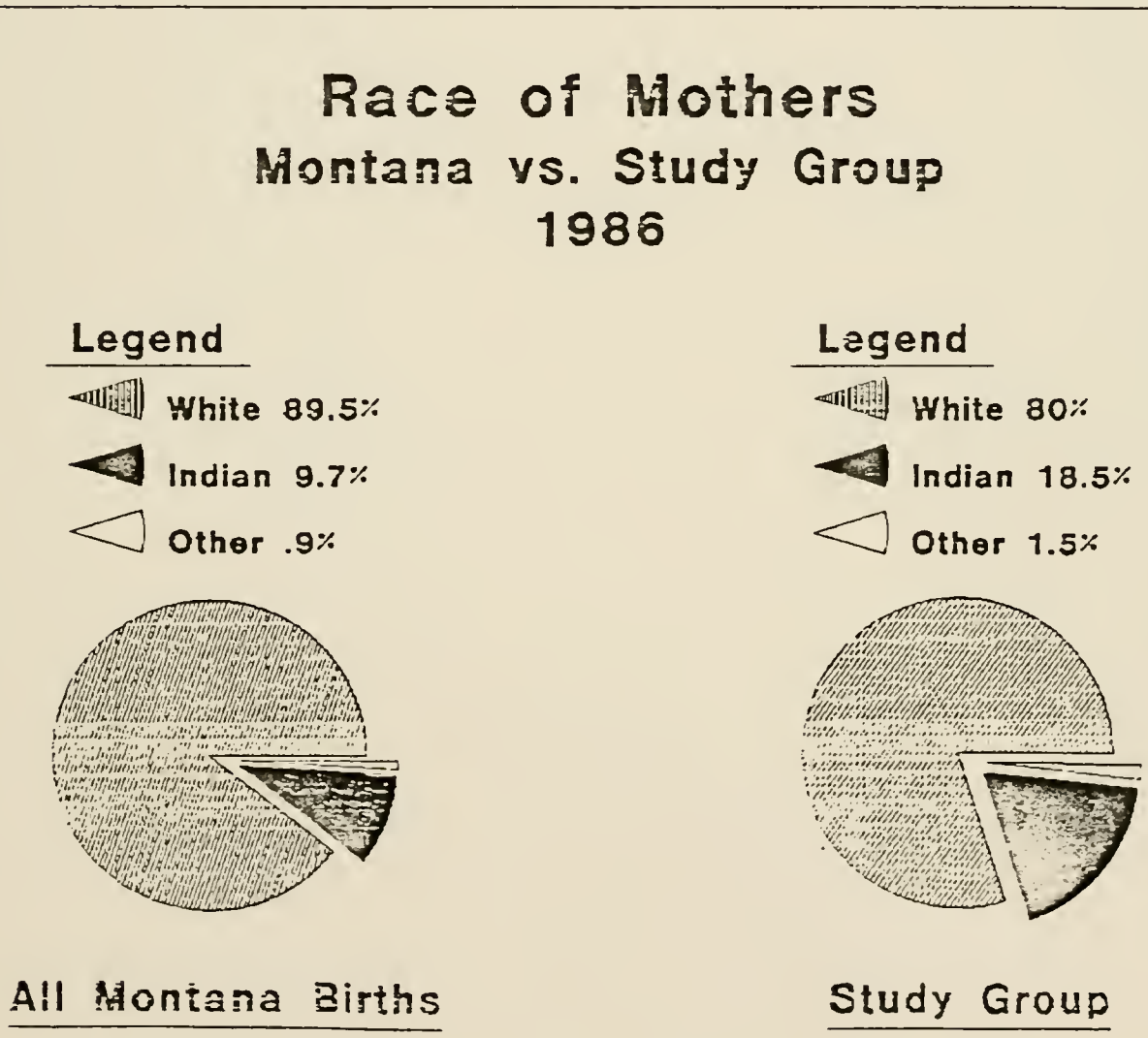
MONTANA GROUP

STUDY GROUP

RACE

Of the 1986 Montana births, 89.5% were to Caucasian women; 9.7% were to Indian women.

Within the study group, 80.0% of the births were to Caucasian women while 18.5% were to Indian women. (The number of Indian women represented in the sample is nearly twice as high as the state average.)



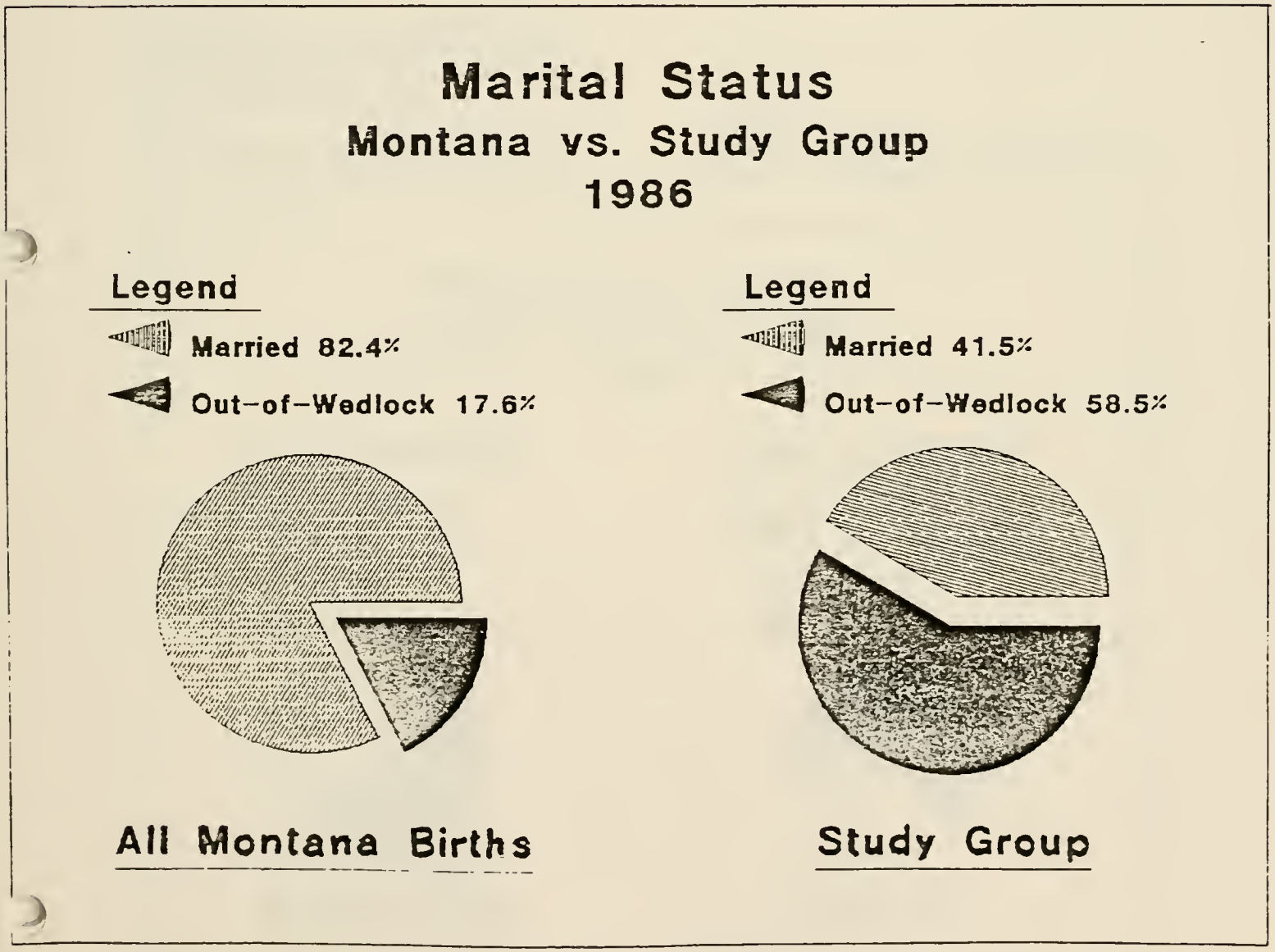
MONTANA GROUP

STUDY GROUP

MARITAL STATUS

Of the total number of Montana babies born in 1986, 17.6% were out-of-wedlock births.

Of the study 58.5% were out-of-wedlock births -- more than three times higher than the state average.



MONTANA GROUP

STUDY GROUP

EDUCATIONAL LEVEL

There were 12,765 women who gave birth in Montana during 1986. Within that group 282 (2.2%) had an eighth grade education or less.

1,606 women (12.6%) had between 9 and 11 years of education.

5,348 women (41.9%) had completed high school.

4,793 women (37.5%) women had at least some post-secondary education.

694 women (5.4%) had completed college and had some post graduate work. (Data for 0.3% of the state group was unavailable.)

In the Montana group, 14.8% had less than a high school education.

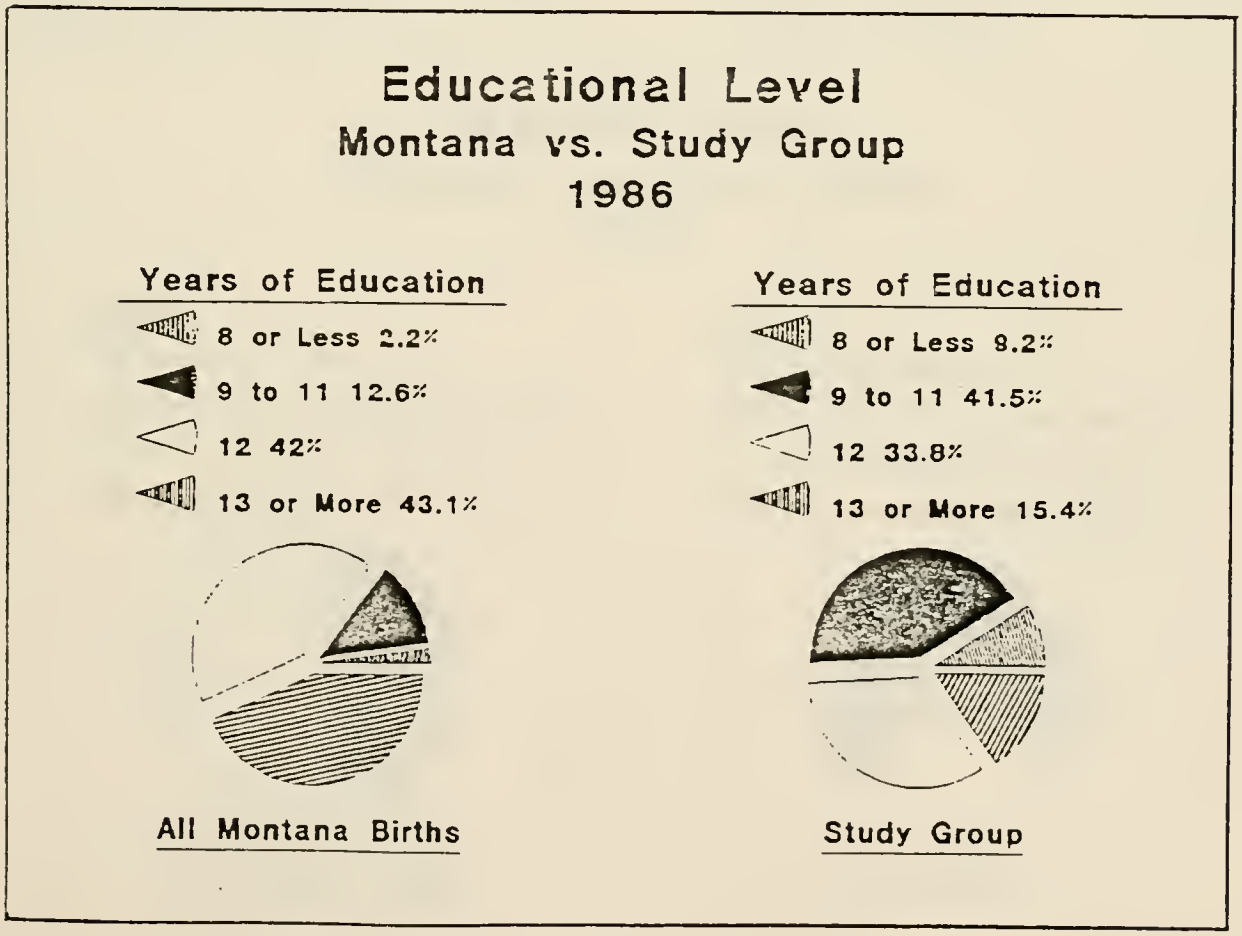
Of the 65 women in the study group, 6 women (9.2%) had an eighth grade education or less.

27 women (41.5%) had between 9 and 11 years of education.

22 women (33.8%) had completed high school.

10 women (15.4%) had at least some post-secondary education.

In the study group, 50.7% had less than a high school education.



MONTANA GROUP

STUDY GROUP

PRENATAL CARE

According to a United States General Accounting Office report, prenatal care is insufficient if it does not begin within the first three months of pregnancy or if there are eight or fewer prenatal visits. According to the American College of Obstetricians and Gynecologists, prenatal care should begin as early in the pregnancy as possible with thirteen prenatal visits considered ideal. Women with medical complications are advised to see a health care provider more often.

77.0% of the state group reported initiating prenatal care during the first trimester of pregnancy.

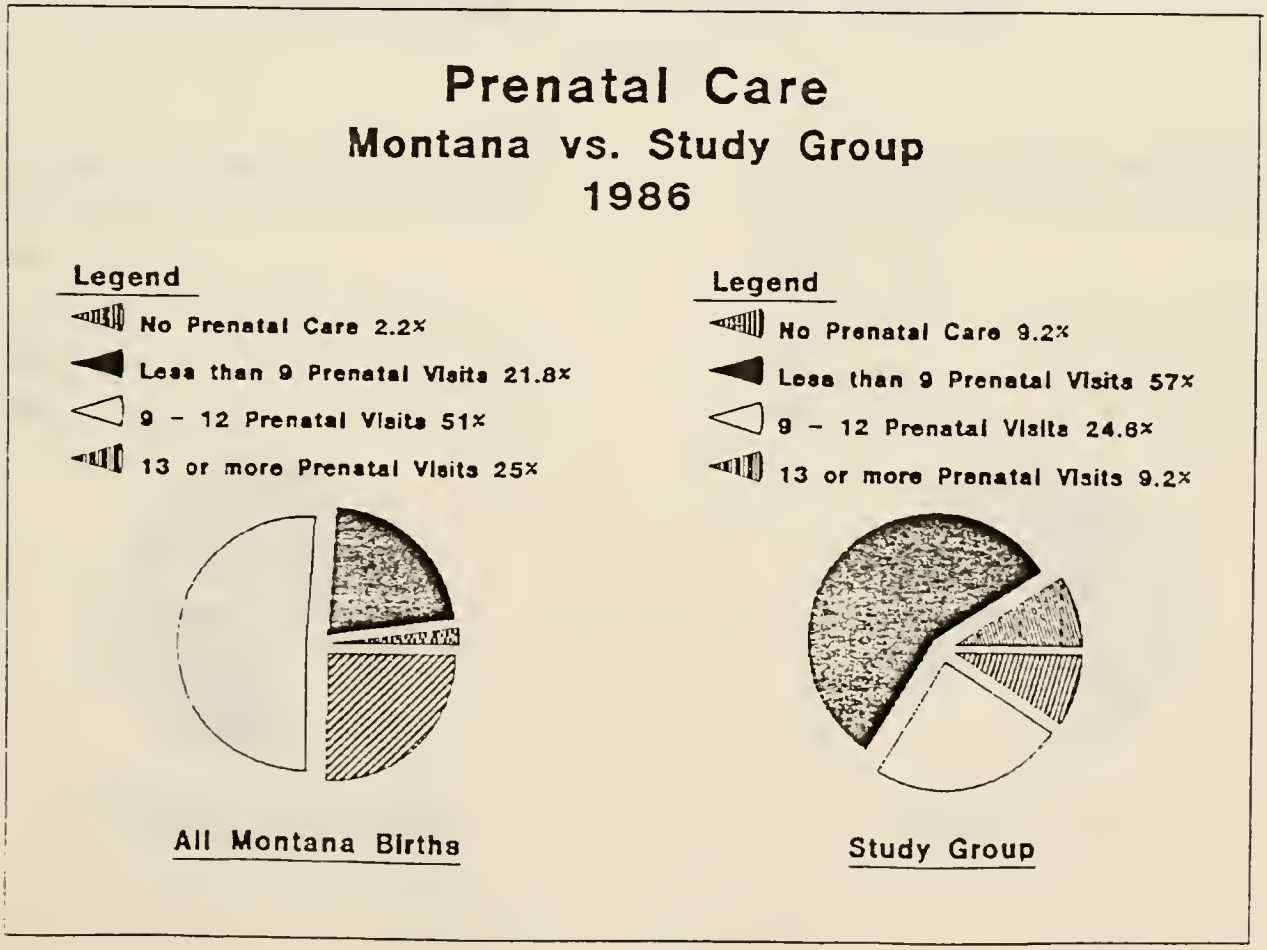
Of the state group, 21.8% reported less than 9 prenatal visits. An additional 2.2% reported no prenatal care or the data on prenatal care was unavailable.

50.9% reported 9-12 prenatal visits. 25.0% reported 13 or more prenatal visits.

55.0% of the study group reported initiating prenatal care during the first trimester of pregnancy.

Of the study group, 56.9% reported less than 9 prenatal visits. An additional 9.2% reported no prenatal care or the data on prenatal care was unavailable.

24.6% reported 9-12 prenatal visits. 9.2% reported 13 or more prenatal visits.



MONTANA GROUP

STUDY GROUP

PREVIOUS PREGNANCIES

Women under the age of 25 in the state group have the following obstetrical history:

46.6% - 0 previous pregnancies
32.4% - 1 previous pregnancies
14.2% - 2 previous pregnancies
4.3% - 3 previous pregnancies
2.5% - 4 or more previous pregnancies

21% of the state group under age 25 had 2 or more previous pregnancies.

Women under the age of 25 in the study group have the following obstetrical history:

37.5% - 0 previous pregnancies
25.0% - 1 previous pregnancies
14.6% - 2 previous pregnancies
16.7% - 3 previous pregnancies
6.2% - 4 or more previous pregnancies

37.5% of the study group under the age 25 had 2 or more previous pregnancies.

Previous Pregnancies

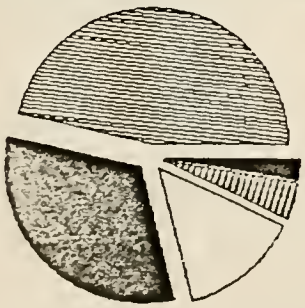
Women Under The Age Of 25

Montana vs. Study Group

1986

Number of Previous Pregnancies

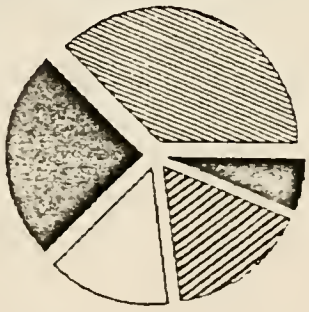
- 0 46.6%
- 1 32.4%
- 2 14.2%
- 3 4.3%
- 4 or More 2.5%



All Montana Births

Number of Previous Pregnancies

- 0 37.5%
- 1 25%
- 2 14.6%
- 3 16.7%
- 4 or More 6.2%



Study Group

MONTANA GROUP	STUDY GROUP

RACE BY AGE

On a statewide average in 1986, 21.8% of the Indian women who gave birth were teens (under the age of 20). Another 36.0% of the Indian women who gave birth were between the ages of 20 and 24. Therefore, 57.8% of Indian women who gave birth in Montana in 1986 were under the age of 25.	Within the study group, 33.3% of the Indian women were teens and another 58.3% of the Indian women were between the ages of 20 and 24. Therefore, 91.6% of the Indian women in the study group were under the age of 25.
11,421 Montana births in 1986 were to Caucasian women. Of this number, 8.7% were to teens. An additional 29.5% were to women between the ages of 20 and 24. (38.2% of the 1986 Caucasian mothers were under the age of 25.)	Of the Caucasian women within the study group, 25.0% were teens -- nearly three times higher than the state average. An additional 44.2% were between the ages of 20 and 24. (Total of 69.2% under the age of 25.)

WEDLOCK BY AGE

On a statewide basis, 58.1% of the teens who birthed in 1986 were unmarried. 21.9% of the women between the ages of 20 and 24 were unmarried.	Within the study group, 94.1% of the teens were unmarried. Forty percent (40%) of the women between the ages of 20 and 24 were unmarried.

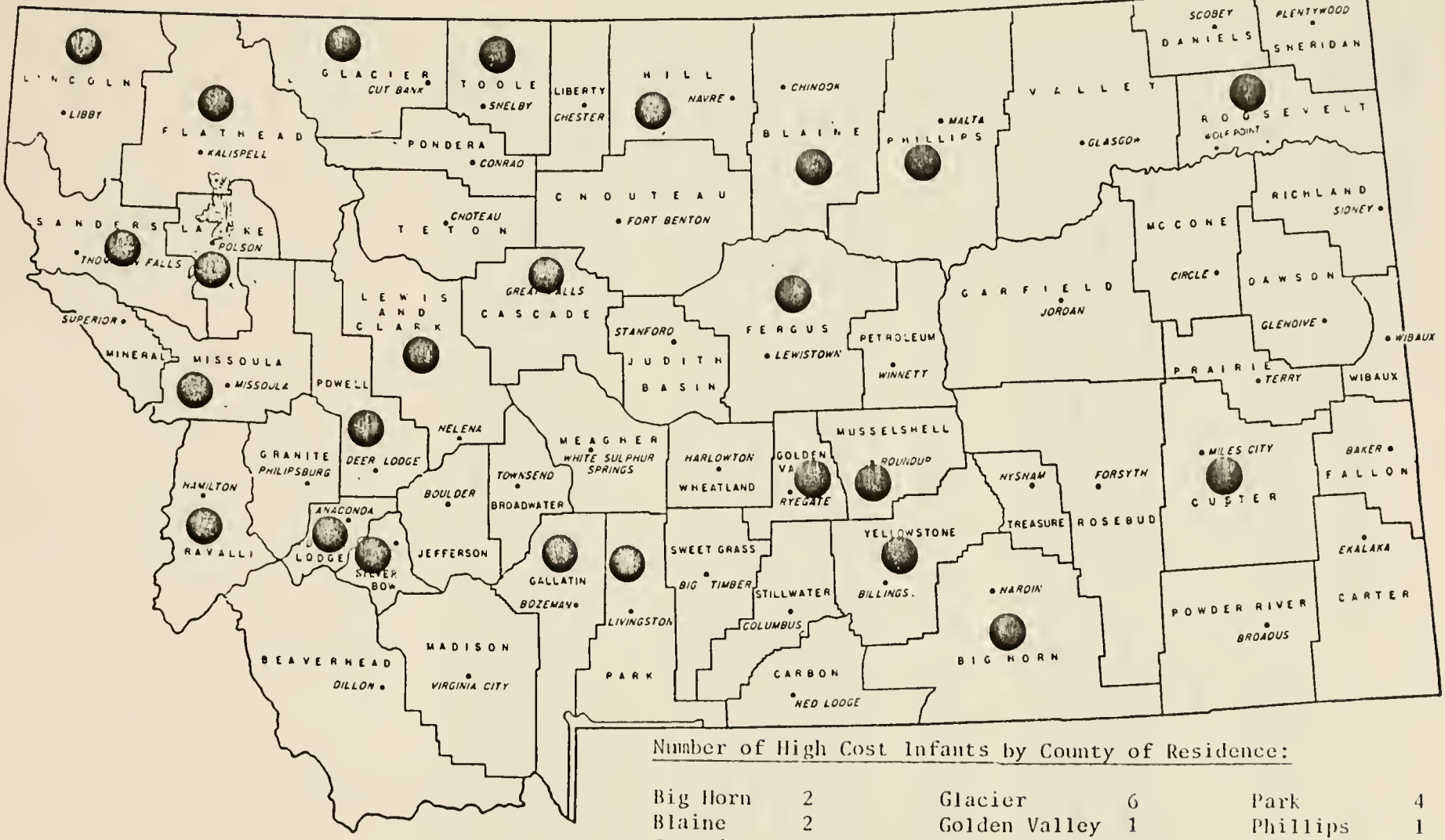
WEDLOCK BY RACE

Of the Caucasian women who gave birth in 1986, 87.1% were married; 12.9% were unmarried.	Of the Caucasian women in the study group, 46.2% were married, 53.8% were unmarried.
Of the Indian women who gave birth in 1986, 38.2% were married; 61.8% were unmarried.	Of the Indian women in the study group, 25.0% were married, 75.0% were unmarried.

COUNTY OF RESIDENCE:

The map on page 16a shows the distribution of these 83 infants according to county of residence.

MONTANA



Number of High Cost Infants by County of Residence:

Big Horn	2	Glacier	6	Park	4
Blaine	2	Golden Valley	1	Phillips	1
Cascade	11	Hill	4	Powell	2
Custer	3	Lake	2	Ravalli	2
Deer Lodge	1	Lewis & Clark	7	Roosevelt	1
Fergus	1	Lincoln	1	Sanders	3
Flathead	4	Missoula	5	Silver Bow	4
Gallatin	2	Musselshell	1	Toole	2
				Yellowstone	11

B. OTHER FINDINGS:

After identifying and comparing the demographics of the two groups, it was necessary to determine:

1. At what point these women applied for Medicaid (prior to conception, during the pregnancy, or after the birth; and

2. Whether the women were eligible with an incurment.

Of the 81 mothers in the study group, the eligibility and incurment data was unavailable on 6 mothers (7.4%). Seventeen (17) mothers (21.0%) were covered by Medicaid 181 to 270 days prior to the birth of the child. Another 7 women (8.6%) were covered 91 to 180 days prior to the birth. Eighteen (18) mothers (22.2%) were covered 1-90 days prior the birth; 33 mothers did not apply until after the birth of the child (40.7%).

Sixteen (16) of the mothers were eligible for the Medically Needy Program with an incurment. The other 59 mothers had no incurment.

In order to estimate the number of pregnant women who applied for Medicaid coverage during a given fiscal year, a program was written and run on the MIMS system for state fiscal year 1988, ending June 30, 1988. The data indicated that 871 pregnant women applied for and received Medicaid coverage during that year. Ninety-one (91) pregnant women applied for Medicaid coverage but were denied. An additional 18 pregnant women were both eligible for and denied coverage during the same fiscal year. Approximately nine pregnant women in ten who apply for pregnancy-related medical assistance are found eligible.

Contacts with medical providers and reviews of claim histories indicated at least ten of the 81 mothers were at high risk due to medical conditions such as diabetes, active herpes virus, infectious parasitic condition, Rh incapatability, liver disease, anorexia, and cervical cancer. Some claim histories and county data strongly suggest psychosocial problems such as substance abuse and family dysfunction.

CONCLUSIONS

V. CONCLUSIONS:

It is important to reiterate that the study sample included only those babies born in 1986 who incurred Medicaid costs of $10,000 or more during the first year of life. These 83 babies represented 2.7% of the infants covered by Medicaid during that year. Therefore, we are not speaking about the welfare population in general.

However, by studying the demographics of these infants and their mothers, it becomes evident that the mothers fit a particular profile. Knowing this profile can help us target our energies more appropriately to help those who are most in need.

A. BIRTH WEIGHT:

Over half the babies in the study group were born with low birth weight. The lower the birth weight, the longer time required for the infant to spend in intensive care and, consequently, the higher the medical costs.

According to studies by the Institute of Medicine:

"Low birth weight is a major determinant of infant mortality in the United States. Infants weighing 2,500 grams (5.5 pounds) or less are almost 40 times more likely to die during their first four weeks of life than the normal birth weight infant. In addition, low birth weight survivors are at increased risk of health problems ranging from neurodevelopmental handicaps to lower respiratory tract conditions."

The Institute further reports that:

"Low birth weight infants are also more likely to have significant congenital anomalies than normal birth weight infants. . . They are also vulnerable to the potential side effects of neonatal intensive inpatient hospital care interventions."

The Institute also indicates that when a woman has had a preterm birth or a baby with intrauterine growth retardation (IUGR), the risk of the same problem in subsequent pregnancies increases substantially.

Although the underlying physiological causes of low birth weight are not clearly understood, a large body of information has been developed about "risk factors". These are certain characteristics which indicate an increased chance of bearing a low birth weight infant. The Committee lists six principal risk factors for low birth weight:

I. Demographic Risks
II. Medical risks predating pregnancy
III. Medical risks in current pregnancy
IV. Behavioral and environmental risks
V. Health care risks

VI. Evolving concepts of risk

The demographic risks include:

A. Age (less than 17 or over 34)
B. Race (Black)
C. Low socioeconomic status
D. Unmarried
E. Low level of education

B. AGE OF MOTHER:

The mothers of the high cost infants were characterized by their youth. Nearly three quarters of the mothers (73.9%) were under the age of 25. More than one quarter of the mothers (27.7%) were teenagers.

Studies indicate that young age is not an independent risk factor for low birth weight. Teenage mothers tend to have many other characteristics which increase the likelihood of a low-weight birth. They are more likely to be of a racial minority, of low socioeconomic status, and unmarried than older mothers. Furthermore, they tend to be less educated and more likely to report late for prenatal care.

C. RACE:

Whereas national studies have found Black women to be at higher risk to have a low birth weight baby, in Montana it is the Indian woman who is at higher risk. Again, it is important to note that 80.0% of the mothers in the study group were Caucasian, so this certainly cannot be characterized as a minority problem. However, Indian women were represented in the study group nearly twice as high as the Indian women in the state group.

D. LOW SOCIOECONOMIC STATUS:

The fact that the women were eligible for Medicaid indicates their low socioeconomic status.

The Institute of Medicine reports that:

> "Low socioeconomic status, measured in terms of social class, income, education, or census tract, is clearly associated with an increased risk of preterm delivery and intrauterine growth retardation. The literature suggests that at least some of the excess risk arises from separate factors linked both to low social class and low birth weight. These include smoking, low maternal weight gain and short stature, obstetric complications such as hypertension and preeclampsia (a toxic condition of late pregnancy), some types of genitourinary tract infections, and limited access to high-quality prenatal care. The effect of socioeconomic status probably represents the sum of many

factors, each of which may increase the risk of poor pregnancy outcomes."

E. UNMARRIED:

Again, the study group was characterized by its high number of out-of-wedlock births.

Studies indicate that unmarried mothers have a consistently higher risk of bearing a low birth weight infant than those who are married. Although it is not felt that marital status is linked with either age or race as a risk factor, the Montana statistics indicate that the younger the pregnant woman, the more likely she is to be unmarried.

F. EDUCATION:

Half the women in the study group (50.7%) had not completed their high school educations compared with 14.8% of the state group.

The Committee to Study the Prevention of Low Birth Weight found that "the risk of low birth weight declines sharply among mothers with at least 12 years of education." Their study further indicated that there is a widening gap in low birth weight rates among mothers with different levels of education. They suggest that the poorly educated may constitute an increasingly high-risk group.

G. OBSTETRICAL HISTORY:

The Committee to Study the Prevention of Low Birth Weight (Institute of Medicine) reports that:

> "The history of a woman's previous pregnancies is of prime importance in the prediction of a subsequent low birth weight infant. A detailed study of the weights and gestational ages of all births in Norway from 1967 through 1973 showed that a premature first birth is the best predictor of a premature second birth and that growth retardation in a first pregnancy is the most powerful predictor of growth retardation in a second pregnancy. Previous fetal and neonatal deaths also are strongly associated with preterm low birth weight, and the risk increases as the number of poor fetal outcomes increases.
>
> The effect of the interaction between maternal age and birth order on low birth weight has been well documented. The incidence of low birth weight is high for women between 15 and 19 bearing their second or later child, low for women age 25 to 34 bearing their third or later child, and increases sharply among women having their first child after age 29."

The parity (number of previous pregnancies) of women in the study group indicates that 62.5% of the women under age 25 had at least one previous pregnancy. Data regarding these previous pregnancies is unavailable so it is impossible to determine whether there was an

obstetrical history of premature delivery and/or low birth weight infant.

Other medical problems identified within the study group indicate that many of the women had severe medical problems. From the data collected, it was impossible to assess the behavioral and environmental risks such as smoking, poor nutritional status, alcohol and other substance abuse. According to a report by the Kentucky Coalition for Maternal and Child Health:

> "A mother who receives ongoing medical supervision and counseling during her pregnancy is more likely to receive adequate nutrition, limit the use of tobacco and alcohol, and eliminate any medications not approved by her doctor. All are important factors affecting the outcome of her pregnancy and her delivery."

The report by the Coalition goes on to state that:

> "Children of mothers who do not secure adequate prenatal care are more likely to experience an increased occurrence of mental retardation, birth defects, growth and development problems, blindness, autism, cerebral palsy, epilepsy, and respiratory distress syndrome. Many of these same children may forever be dependent upon society for their care, both as children and adults."

Yet, the data indicates that 66.2% of the women in the study group received inadequate prenatal care, even though the identifiable risk factors were great.

Furthermore, the vast majority of these women were eligible for Medicaid with no incurment (79.7%). However, nearly two-thirds of these women (62.9%) did not apply for Medicaid benefits until shortly before or after the birth of the child.

H. COUNTY OF RESIDENCE:

Because of the small sample size (83 infants), no conclusions can be drawn regarding the distribution according to county of residence. With the exception of the more populous counties, this distribution could be expected to shift from year to year.

REFERENCES

VI. REFERENCES:

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RECOMMENDATIONS
BASED ON THE
STUDY OF

HIGH COST MEDICAID INFANTS

PRESENTED
TO

LEE J. TICKELL, ADMINISTRATOR
ECONOMIC ASSISTANCE DIVISION

BILL HARRINGTON, CHIEF
FIELD AND PROGRAM MANAGEMENT BUREAU

JOHN CHAPPUIS, CHIEF
MEDICAID SERVICES BUREAU

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

BY
PRENATAL CARE COMMITTEE

JANUARY, 1989

SUMMARY

SUMMARY

Based on the findings of the study on high cost Medicaid infants, the committee makes the following recommendations for consideration by the Department's Administration:

A. OBRA-Related Options:

1. That "Presumptive Eligibility for Pregnant Women" be reevaluated in 1990.

2. That "Coverage of Poor Pregnant Women and Infants to Age One Year at 185% of Poverty" be reevaluated after the state has expanded coverage for pregnant women to 75% and 100% of poverty, respectively.

3. That "Extended Coverage to Poverty Pregnant Women and Infants up to Age One" be phased in as permitted by federal law and that the resource test be continued. We further recommend that this option be reevaluated at the end of fiscal year 1990 to determine whether increased numbers of pregnant women are being denied Medicaid benefits due to excessive resources.

4. That the "Provider Base for Primary Health Care Services" be expanded to include public health departments or other health care clinics which:

   a. Are under the direction of a physician; and
   b. Provide prenatal health care services.

5. That a "Case Management" system be implemented. Such a system would facilitate early application for Medicaid coverage as well as early and consistent prenatal care services for the targeted high risk group.

6. That "Continuous Eligibility" be further investigated by contacting states that have already implemented this option.

In addition to these OBRA-related options, the committee recommends the following for consideration:

1. That any action affecting Medicaid eligibility or medical assistance to pregnant women in Montana be undertaken with a clear focus on the goal -- namely, the delivery of a healthy baby.

2. That efforts be targeted toward the population which was identified through this study to be at high risk for delivering a low birth weight baby.

3. That a public campaign be initiated to educate all women, particularly the target population, on the importance of early and consistent prenatal care.

4. That the Department of Social and Rehabilitation Services implement and facilitate training workshops for eligibility technicians throughout the state regarding dealing with a pregnant applicant or client.

5. That the Department of Social and Rehabilitation Services work with other interested agencies in making pregnancy-related information available to clients.

RECOMMENDATIONS

RECOMMENDATIONS:

Based on the results of the study on high cost Medicaid infants, the Prenatal Care Committee recommends the following:

A. OBRA-RELATED OPTIONS:

1. PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN:

In Montana, AFDC-related Medicaid applications must be processed within thirty (30) days. Checks with counties indicate that a number of counties routinely process such applications within a shorter time period. Whereas the Committee does not wish to discount presumptive eligibility as a viable option, we feel that other alternatives are more appropriate for the targeted population at this time.

Implementation of presumptive eligibility would require a great deal of county support in terms of time and procedural changes. The Committee feels that, prior to the implementation of TEAMS, such a commitment would place a great deal of strain on county offices.

We recommend that the option be reevaluated in 1990.

2. COVERAGE OF POOR PREGNANT WOMEN AND INFANTS TO AGE ONE YEAR AT 185% OF POVERTY:

Although it cannot be determined why one in ten pregnant women in Montana who apply for Medicaid are being denied Medicaid benefits, it is assumed that the inability to meet the incurment may be the major reason for such denials.

The Committee proposes that data on approvals and denials for this population be rerun after fiscal years 1990 and 1991, when coverage for pregnant women has been expanded to 75% and 100% of poverty, respectively.

3. EXTENDED COVERAGE TO POVERTY PREGNANT WOMEN AND INFANTS UP TO AGE ONE:

Whereas expanded coverage is mandated to 100% of poverty by July 1, 1990, states may choose to go to 100% sooner. The use of a resource test for this population is optional.

The Committee recommends that Montana phase in coverage as allowed by federal law -- extending coverage to 75% of the poverty level on July 1, 1989 and 100% of the poverty level on July 1, 1990.

The Committee further recommends that the resource test be kept because the target group is less likely to be affected by its elimination. However, we propose that this option also be reevaluated at the end of fiscal year 1990 to determine whether

increased numbers of pregnant women are being denied Medicaid benefits due to excessive resources.

4. EXPANDING THE PROVIDER BASE FOR PRIMARY HEALTH CARE SERVICES:

The development of case management services for the high risk prenatal clientele will require a comprehensive approach and a primary focus on obtaining quality health care services. Typically, primary prenatal health care services are provided by physicians in private practice. There is a need to provide the private physician with the means of linking the high risk pregnant woman into the case management system.

It is feasible to consider development of prenatal health care services and include case management services under local county health departments available throughout the state. The prenatal services would include the physician or nurse practitioner exam as well as the public health nurse working closely with those clientele who are identified as requiring supervision with management of their prenatal services.

Medicaid could reimburse for exams provided by licensed physicians as well as an established fee for the case management aspects.

5. CASE MANAGEMENT:

The Committee feels that this option bears the greatest consideration given the demographics of the target population and recommends that Case Management be utilized to facilitate:

a. Early application for Medicaid benefits; and

b. Early and consistent prenatal care.

The Committee recommends that the case management facility have a health care focus but also be able to deal with the economic, environmental, and psychosocial elements which may be present. The Committee further recommends that such health care facilities be places where women go for pregnancy testing such as family planning clinics or public health departments.

It would be the responsibility of the Department of Social and Rehabilitation Services to:

a. Provide up-to-date information regarding eligibility criteria and procedures to these facilities;

b. Train case management personnel to assist potential recipients in completing the Medicaid applications and in making appointments at the county welfare offices and to inform potential recipients about materials and information they should bring to their appointments; and

c. Provide application materials and program brochures and other information, as appropriate.

6. CONTINUOUS ELIGIBILITY:

Recommendations regarding this option could not be made on the results of this study. However, the Committee recommends that, due to the fiscal and administrative impacts, further research be undertaken. Twenty-seven states have chosen this option. We recommend that a sample of these states be contacted to determine how it is working.

B. OTHER RECOMMENDATIONS:

1. That any action affecting Medicaid eligibility or medical assistance to pregnant women in Montana be undertaken with a clear focus on the goal -- namely, the delivery of a healthy baby.

2. That efforts be targeted toward the population which was identified through this study to be at high risk for delivering a low birth weight baby. This population is comprised of unmarried women under the age of 25 who have not completed their high school educations and who are economically deprived. Special attention should be paid to Indian women who fit this profile.

3. That a public campaign be initiated to educate all women, particularly the target population, on the importance of early and consistent prenatal care.

Plans are currently being formulated through the Montana Healthy Mothers/Healthy Babies Coalition to adopt the public information campaign, "Baby Your Baby" which was developed by the State of Utah a few years ago. Through a multi-media approach, the campaign advertises a toll-free number which a pregnant woman can call. (The number is hooked into an answering service 24 hours per day.) The woman gives her name, address, and telephone number and is sent a registration card. Once she completes and returns the card (co-signed by a health care professional), she is sent a gift and informational packet. This packet could contain information regarding:

- Medicaid
- Child Support Enforcement
- Prenatal care facilities
- Other information regarding state agency resources

Two times during the year, a documentary is aired. This documentary is designed to stimulate viewer questions. At that time, the toll-free number is staffed by volunteers who can answer questions and refer callers to appropriate agencies within their communities.

In addition to the documentaries, the "Baby Your Baby" project involves a complete package of public service announcements, billboards, etc.

The professional public relations agency which is developing this package for the Montana Coalition is in the process of seeking financial support for this project from large corporations or other interested entities.

The "Baby Your Baby" project reportedly cost $2.5 million to implement in Utah over a two year period of time. Implementing a similar project in Montana is estimated to cost approximately $300,000. A corporate sponsor would be asked to contribute approximately $75,000 for the two year period.

It is recommended that the State of Montana consider endorsing this project by becoming a corporate sponsor. This would allow coordination of information from all state agencies with a minimum of staff involvement. The media exposure would be far greater than any one agency could hope to gain through conducting its own campaign and the cost would be far lower.

5. That the Department of Social and Rehabilitation Services implement and facilitate training workshops for eligibility technicians throughout the state regarding dealing with a pregnant applicant or client. The training would emphasize the ultimate goal -- healthy babies. The technicians would investigate their attitudes toward unmarried, young pregnant women and would be trained to respond to such women (and, consequently, all other clients) with greater compassion, encouraging prenatal care and referring to a case management team (where such team is operant).

6. That the Department of Social and Rehabilitation Services work with other interested agencies in making pregnancy-related information available to clients. For example, Medicaid brochures could be placed in Family Planning clinics; Check stuffers could be developed for the business offices of providers, informing pregnant women of Medicaid benefits; WIC (Women, Infants, and Children), family planning, and other literature and posters could be placed in county welfare and human services offices.